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Psychosocial Experiences among Postnatal Women after Caesarian Section in the Tamale Metropolis, Ghana

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Background: Worldwide about 20 million women give birth through surgical intervention and as such it is placed first among operative cases in most hospitals. Little is known about how this method of delivery affects the psychosocial health of the mothers. Yet, the rate keeps on increasing. This study sought to explore the psychosocial experiences of women who have undergone caesarian section (CS) in the Tamale Metropolis.
Methods: This is an exploratory and descriptive study with a qualitative approach. Data was collected through in-depth interviews of twelve (12) purposively selected women, 18 years and above who underwent CS within six (6) months to one (1) year prior to data collection period. Interviews were audiotaped, transcribed verbatim and analysed using thematic analysis.
Results: The study revealed the participants exhibited different emotive reactions such as depression, anxiety and positive emotions towards caesarean section. The women's description of depression centred on sadness, crying and unhappiness. For anxiety, it centred on worry, being scared, afraid, and apprehension. The news on CS was welcomed by few participants because they felt they stood to gain from the procedure. This attitude of few participants was grounded on their

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earlier refusal to undergo the procedure which resulted in a negative outcome to them. Following the CS, the participants had some unpleasant experiences with marital and social contexts. For some of these women, their in-laws advocated for a second wife for their sons to give birth to additional children, others were verbally abused and seen as less of a woman. Others were poorly received at home after their second CS.

Conclusion: Psychosocial experiences shared by the participants had cultural and social dimensions; hence there is the need for public health units and workers to intensify public education on CS to enhance the needed support for women who undergo caesarian section.

Keywords: Caesarian section; psychosocial; emotions; thematic analysis.

1. INTRODUCTION

Among the challenges women face during childbearing years is the choice of the mode of delivering a baby and its acceptability in their social context [1]. Women will prefer CS over normal birth because it frees them from the pain associated with spontaneous vaginal delivery because it is believed that, with CS, their lives and that of the babies will be freed from any form of danger [2]. On the other hand, vaginal delivery is considered as a choice of birth that ensures a good relationship between the mother and the baby right from birth. It is considered as a form of delivery that allows mothers to resume their daily routine of work and their lives and that of the babies is less endangered as compared to that of CS [3-5].

Current studies have revealed an increased request for CS among women worldwide, among high and low-income countries [6]. With reference to existing statistics from 150 countries, presently 18.6% of childbirth results in surgical birth, 6% from less industrialized countries and 27.2% from industrialized countries respectively [7]. In addition, assessment of trends in rates among industrialized and underdeveloped countries demonstrates that the increase was 14.6% (from 6.3% in 1990 to 20.9% in 2014) in underdeveloped, and 12.7% in industrialized countries (from 14.5% in 1990 to 27.2% in 2014) [8].

Worldwide, surgical delivery of a baby becomes necessary due to some of the following reasons; transverse or breech presentation of the baby, failure in the progress of labour, foetal abnormalities, foetal macrosomia, ill health of the mother, placenta previa, bleeding in pregnancy [9]. In addition, maternal features such as age, number of previous deliveries, weight of the mother and a mother with a narrow pelvis contributes to the conduction of CS [4,8].

Regardless of the benefits CS offer to mothers and their newborn babies, it is not without effects. These may include bleeding, fetal growth restriction, delivery before term, and possible stillbirth. Long term maternal illnesses may include pelvic pain and adhesions. It is a belief that CS causes a decline in the number of children one intends to have and heightens a couple's susceptibility to unintentional pregnancy loss and ectopic pregnancy [2,10]. The rise in newborn illness and death are linked to surgical birth in low-income countries in addition to the risk of being admitted to neonatal intensive care unit [4,11]. In most sub-Saharan African countries, women are not willing to accept CS as a mode of delivery. The influencing factors for this phenomenon include, CS being perceived as a form of punishment to a promiscuous woman, a way of helping women without strength to give birth, and the fact that it is also seen as a failure to womanhood in their social context [4].

The low uptake of CS as a means of childbirth in sub-saharan Africa may stem from shared understanding of the basic factors mentioned above and other misconceptions society may have about natural deliveries as against assisted delivery. Research points to the fact that some women will run away from the hospital after they have been booked for the procedure only to resort to their religious leaders for divine interventions [2,12]. On the other hand, women embraced CS when the option was discussed with them because they felt the procedure was sufficient enough to relieve them of stress and discomfort, it was a way of maintaining their integrity as women and sure way of having a healthy baby [2,13]. This was evident in a study conducted in Cambodia which showed that pain and fear inside labour wards drive women to request CS during labour. Similarly, most pregnant women will request for CS due to lack of support in the labour room, lack of pain-relieving interventions during spontaneous vaginal delivery [14]. In a study conducted by

Mboho, (2013a) [15] on, women's self-reported experience of unplanned CS among Swedish women, childbirth-related fear was common among women one year after birth with 32% describing their fear as moderate or strong. Studies have revealed that between 24 and 33% of women who had an unplanned CS experience intrusive posttraumatic stress symptoms such as flashbacks and dreams six (6) months after childbirth, and 1.5 to 3% of them actually experience Post Traumatic Stress Disorders (PTSD) [16].

Women suffered in their marital homes after they underwent CS in that, they had to either share their husbands with other women who the family believed would give birth to other children to keep their lineage going. In other instances, women had to leave their marital homes to give way for other competent women to build the family lineage [4,12]. Caesarian Section to them, limits a woman's ability to give birth to many children. Studies reported that, women who underwent CS were being maltreated in the community they live in either by their rivals, friends or immediate associates. These women were being teased at and as such those yet to be operated on refused to undertake CS as a birth strategy. In another study conducted by Karlström et al., (2017) [17] in Nigeria, women showed their dislike for CS after seeing how other women have been maltreated in the past in their social groups for opting for CS as a birth strategy. In the study area, CS is viewed with hatred, misconception, anxiety, quilt, misery and anger. Women are not willing to opt for CS due to the negative perception of the procedure. In Ghana, little is known about how this method of delivery affects the psychosocial health of the mothers. The purpose of this study was to explore the psychosocial experiences of women who have undergone CS in the Northern Region of Ghana. The research questions for this study were therefore;

1. What are the emotions associated with CS?
2. What are the social consequences of undergoing CS?

2. MATERIALS AND METHODS

2.1 Setting

The study was conducted in the Tamale Metropolis from January, 2018 to June, 2018. Tamale is located within the Northern sector of Ghana. It is one of the six (6) Metropolitan Assemblies in Ghana. It has the largest land mass in Ghana. The Tamale Metropolis is located in the central part of the Region and shares borders with the Sagnarigu District to the west and north, Mion District to the east, East Gonja to the south and Central Gonja to the south-west. The Metropolis has a total projected land size of 646.90180 sqkm [18]. The Tamale Teaching Hospital serves as the main referral center for hospitals and clinics within the Northern sector of Ghana. The facility provides general services and specialist services. There are various departments in the facility.

2.2 Study Design

This is an exploratory and descriptive study with a qualitative approach. This is highly favoured for research enquiries which seek to get an in-depth understanding of a situation, to generate new ideas based on participants' responses and to have a better insight to a phenomenon [19,20].

2.3 Target Population

The study population comprised of all women who underwent CS and were residing within the Tamale Metropolis at the time of the study.

2.3.1 Inclusion criteria

The study involved all women aged 18 years and above, who underwent CS within the last six (6) months to one year prior to the data collection who lived within the Tamale Metropolis. Only women who were willing to participate in the study were recruited.

2.3.2 Exclusion criteria

Women who underwent CS but needed emergency care at the time of the data collection were not eligible. Where medical or clinical evidence suggested a potential participant was mentally challenged or emotionally imbalanced, they were excluded from the selection process.

2.4 Sampling Technique and Sampling Size

The study used a purposive or judgmental sampling method to recruit women who underwent CS and consented to participate in the study. The sample size for the study was determined by data saturation. Data saturation was reached by the time the 12th participant was interviewed. Data saturation in qualitative

research describes a point in time during data collection where no new information is generated after interviewing a good number of participants [21,22].

2.5 Data Collection Instrument

A semi- structured interview guide with only open-ended questions was used to collect the data involving in-depth face to face interviews. The semi- structured interview guide was developed based on the study objectives. The interview guide contained two sections. The first section mainly obtained demographic information while the second consisted of main questions and probes. Generally, the questions explored how women reacted to CS and women experiences after they have undergone CS. The interview guide was piloted using three women who met the inclusion criteria from Tamale West Hospital. The aim was to ensure clarity of the guiding questions. All ambiguous questions were noted and reviewed at this stage. To avoid false information data from the piloted study were excluded from those obtained from the actual study.

2.6 Data Collection Procedure

In recruiting participants for the study, the researcher identified potential participants from the maternity unit records of the Tamale Teaching Hospital where their addresses and contact numbers were retrieved. Each participant was made to thumbprint or sign two consent forms to indicate her willingness to take part in the study. The participant kept one consent form while the researcher kept the second for future reference and as part of an audit trial. This was done after the essence of the study was explained to them by the researcher. Data for this study was collected from women who experienced CS and were 18 years and above. Privacy was ensured during the interview session by avoiding crowded environment.

During the interview session, the researcher communicated with the participants in the language both parties could understand. The researcher equally trained a translator to obtain information from participants especially in Dagbani the most spoken language among inhabitants in the metropolis. The information was then transcribed to English by the same translator. All data that was gathered was audiotaped using a digital audio- recorder in addition to written field notes. On average, each interview lasted for about forty minutes.

2.7 Data Management and Analysis

All interviews were transcribed verbatim and cross-checked for accuracy and completeness by replaying the audiotaped information and comparing with transcribed data severally. For easy reference to each respondent's responses, the transcribed data was assigned unique codes in the order in which they were recorded.

Pseudonyms were assigned to individual files for easy identification of each participant. Thematic analysis was used to analyze the data from the transcribed participants' narrations. Codes that were in line with emotions, and the social consequences of birth-related surgeries were identified out of this. Comparable codes were put into categories to form sub-themes which had the possibility of falling under either emotional or social implications of CS.

Linked subthemes which have the emotional and social effect on women undergoing birth related surgeries like CS were put together to form major themes. The researchers then reviewed the two main themes which were emotions associated with CS and social consequences of CS to ensure that the themes have a connection with the coded transcripts and the whole of the data. The two main themes (emotions and social consequences) were then labelled with descriptive subheadings in a file. Each transcript was handled in this same manner.

3. RESULTS

In all, 12 women who underwent Caesarian Section (CS) participated in the study. The ages of the mothers ranged from 22 to 49 years. Majority of the participants representing eight (8) were Muslims while the remaining four (4) were Christians. All the participants indicated they were married. Three (3) of the participants had three children and delivered them through CS, three had two children through CS, Six (6) others had only one child through CS, which includes one woman with seven (7) children who delivered her last born through CS. Most (7) of the mothers had tertiary education with few (5) Senior Secondary School leavers. Majority (9) of the women understood and spoke Dagbani. Three (3) could neither speak nor understand Dagbani. Majority (10) were fluent in English with two who could speak and understand English but were not fluent in it. Table 1 presents an overview of the participants in the study. In all, twelve (12) women who underwent CS participated in the study.

Table 1. Demographic characteristic of study participants

Variables	Frequency (N)	Percentage (%)
Overall Participants	12	100
Age of participants		
20-29	4	33.3
30-39	7	58.3
40-49	1	8.3
Religion		
Christians	4	33.3
Muslims	8	66.7
Educational Level		
SSS/secondary	5	41.7
Tertiary	7	58.3
Marital Status		
Married	12	100
Number of Children		
One child	6	50.0
Two children	3	25.0
Three children	2	16.7
Seven	1	8.3
Number of Caesarian Sections		
One	6	50.0
Two	3	25.0
Three	3	25.0
Languages Spoken		
Fluent in English	10	83.3
Either spoke or understood Dagbani	9	75.0
Neither speak nor understand Dagbani	3	25.0

Using the thematic analysis method, the researchers came out with two main themes and five (5) subthemes in all.

3.1 Themes and Subthemes

The two main themes from this study were, “Emotions associated with Caesarian Section”, and ‘Post Caesarian Section consequences. For emotions associated with CS, three subthemes were identified, and they were Anxiety, Depression, and Positive emotions. For the second theme which was post-CS consequences, the subthemes were, marital and social consequences.

3.1.1 Emotions associated with CS

The narrations from the participants indicated they reacted differently on hearing that they were to undergo Caesarean section. Their level of acceptance of caesarean section as a birth method was also seen from their narratives. Based on the Participants narrations, the following subthemes were identified which showed their reaction to CS namely; depression, anxiety and positive emotions.

3.1.1.1 Depression

From the main theme of emotions associated with CS depression featured as the first subtheme. The participating mothers expressed this in many forms. From the narrations of some of the participating mothers, they expressed depression in the form of sadness, by way of crying. In the view of the mothers, they were first-time clients in terms of surgical procedures. According to them the expressions from friends worsened their situation. To other participants, their sadness stemmed from fear of dying during the procedure. Others also expressed sadness due to the fact that they will have to stay in the hospital to the detriment of the other children at home especially when they have to stay at the hospital for longer periods of time.

The quotes below from participants indicate how crying was seen as an expression of depression from fear of dying.

When they told me they will operate me, immediately I was crying, because I heard that sometimes, they may operate women and the person will die.

Another narration to illustrate the feeling of depression, especially stemming from information received about CS from friends and the fact that they were first-time clients of CS is illustrated below.

When they told me about the CS, I was sad; because I have never gone through operation but the way I hear people talk about operation, if you have spontaneous vaginal delivery (SVD), it is better than the operation.

Another narration to further illustrate feeling of sadness especially for reasons of having to leave other children at home is evident in the narrative below.

… I wasn't happy at all. How will the other six (6) children cope? When I was leaving the house, I had prepared myself as usual that when I go to deliver that day, I will come back. That was what I told my children and I came to the hospital only to stay for almost five days. I was not happy with the CS.

3.1.1.2 Anxiety

As a second subtheme under emotions associated with CS, some of the participants in the study reported that they were anxious after receiving the information that they were going to be operated on. Their description of anxiety centered on worry, being scared, afraid, and apprehensive. To others, the subtheme anxiety was expressed in the form of worry because their wish was to go through spontaneous vaginal delivery, and to be seen as women in their social context. Further, data from the participants revealed that, they were anxious because they were experiencing CS for the first time, and were afraid because of the unpleasant stories they have heard about CS. Thus, these women were particular about the outcome of the procedure.

The following statement gives credence to the feeling of worry because of her feeling of being incompetent.

Caesarian section is a worry to me. I am very worried even up till now. I wish I could have been giving birth through my vagina to avoid the nonsense and other unpleasant words I hear from my friends which I cannot respond back. They say am not a woman because I cannot deliver by myself.

The following narratives from some participants showed how anxious they were about CS due to fear of the unknown;

I was afraid because I didn't know what operation is and how it is done. I hear people say, they kill you and take the baby out. So, I was afraid I will I die? I was just praying that they will do it successfully.

When I was told I will be sent to the theatre for CS, it wasn't easy but I had to. There was this anxiety. I did not know what will actually come out of the surgery, so that one alone brings some kind of fear

Another participant, Abigail a mother of one (1) expressed anxiety in the following narration.

Every day I was apprehensive, the nurses told my husband to get me something that will take my mind off the operation. My husband bought me a new phone with some funny videos and still I was just thinking about the outcome and my heart keep on beating.

3.1.1.3 Positive emotions

As a last sub- theme under the theme emotions associated with CS, some participants showed positive emotions toward caesarean section because of the beneficial aspect of having the operation. This stem from the fact that they have been informed in the past of the possibility of not having children by SVD due to gynaecological issues. Having the CS was not a worry to them but rather it boosted their confidence of safe delivery. In the narration of other participating mothers, they expressed joy because attempted vaginal delivery was prolonged and came with unbearable pain. Caesarian section was therefore seen as a relief to their labour problems. To some, CS served as a remedy to previous stillbirth in their attempted vaginal delivery. Their explanations were that they had been advised to have CS in the past and their non-compliance led to loss of their babies in the past. They concluded by indicating that there is no reason to refuse CS as a mode of delivery

from the knowledge they have now and will even opt to have more of CS in future deliveries.

To explain CS versus previous gynaecological issues a mother of three through CS shared this;

> *When I was diagnosed of having a fibroid, the doctor made it known to me that I may not be able to have children. He said if am married and am pregnant, I should come back. I was just grateful that I have been able to have a child, and I was happy by whatever means the baby was delivered. I bored the pain.*

To further illustrate the benefit of CS, another participant had this to say especially for prolonged labour;

> *When they operated me, I was happy, because I laboured for three days and could not deliver in the house and they brought me to the hospital and operated me.*

A 32-year-old teacher, who was once operated on yet lost her first child because she delayed at home due to her desire to deliver naturally on arrival at the hospital expressed strong positive emotion towards CS.

> *I like the fact that I was operated and I had my baby. The first one, I was operated yet I didn't get my baby because I delayed going to the hospital. This one they booked me for the CS and I complied and I had my bouncing baby girl. In fact, I feel good about it, there is nothing about CS somebody will say again that will scar me. If my third delivery I have to go for CS, I will even dance to the hospital*

3.1.2 Post caesarean section consequences

Post CS consequence as the second main theme emerged contextually from the data. Even though CS is a lifesaving procedure, women suffer in the social context in which they find themselves after the procedure. Two main subthemes regarding the consequences of caesarean section were reported by the participants. These included marital consequences and social consequences.

3.1.2.1 Marital consequence

Marital consequence was identified as the first subtheme under Post CS consequences. The participants expressed that in the social context in which they found themselves, the number of children a woman can give birth to was important to the family and as such their marriages were being threatened based on the perception that CS restricted a woman's ability to give birth to many children. For some of these women, whilst their in-laws were advocating for a second wife for their sons to give birth to additional children, others were verbally abused by their husbands.

Narrations from some participants illustrate how CS can disrupt a woman's marriage and how women are abused after CS;

> *The truth is that no mother in-law in our culture will sit and watch you deliver only three children or so for the son; even after the second CS, she will start to look for another woman for the son for more children, it has happened to me. They know as for CS it is only three children that you can give birth to.*

Another narration provides more evidence

> *Whenever we quarrel, he will just tell me my mouth is too sharp yet common childbirth I cannot deliver on my own unless they operate me. He keeps on telling me to wait and see, I do not know what he wants to do, but you know our people maybe he wants to bring in a second wife.*

3.1.2.2 Social consequences

Social consequence featured as the second subtheme under Post CS consequences. Women in the study experienced some form of social abuse in their respective communities after the CS. For some of the participants, they were seen as less of a woman, and less value attached to the children they had given birth to because they failed to give birth by SVD. The women also indicated that less attention was paid to their contributions in their social groups and in some instances, they were prevented from contributing to conversations. That aside for some they were poorly received at home after their second CS with the notion that after two successive CS a woman cannot give birth to more children.

The expressions below illustrate how socially women are treated after CS;

During weddings, naming ceremonies when you are with your friends, they will make comments like, it is only women who give birth through SVD that are considered women, but through CS you shouldn't call yourself a woman. Even, they say the baby you have given birth to through CS, that baby cannot be compared to the baby who was delivered through SVD.

When you go through CS and you are with your friends and you want to contribute to a conversation they can shut you down, or whatever you say, they will pretend they have not heard you. I pray they will all go through this CS thing

The atmosphere at home, it was not conducive like the way they received me after my first CS delivery. They know that when you go through CS twice, the rest you can't give birth naturally and to so many children. The people in my house were not nice to me at all.

4. DISCUSSION

4.1 Emotions Associated with CS

The findings under emotions associated with CS indicates that, even though the women knew the benefits of CS, they exhibited different emotions. While some showed signs of depression, others were anxious because they did not know what the outcome of CS might be. For those who were unhappy about CS, unplanned CS delivery coupled with longer hospital stay was a factor. The unexpected lengthy stay at the hospital could present challenges to these women, preventing them from fulfilling their socially-expected responsibilities at home. This finding supports that of similar studies which revealed that women preference for vaginal delivery was largely based on the fact that it allows them to resume their daily routine of work early which CS does not offer [3,4]. Some other evidence has postulated that, childbirth regardless of the problems that come with it is a significant and empowering human event and achievement [23]. Also for some other study participants, it was based on the social beliefs surrounding CS. Studies have shown that for women who undergo CS, they are labelled as promiscuous, lazy and disrespectful [4]. Contrary, Størksen, Garthus-Niegel, Adams, Vangen, & Eberhard-Gran (2015) [24] have proven that women's decision to have a CS was influenced by fear of childbirth, even though these women ended up delivering spontaneously. They further stated that many women are afraid of CS but will regardless choose CS as a mode of childbirth. Other women were worried, scared, afraid and apprehensive after receiving the information that they were going to be operated on to have their babies delivered. The social belief that one is not a "woman'' after CS, being a perceived adulterous woman were the concerns of these women which resulted in their worry. These concerns were similarly reported by women in the work of [4]. That notwithstanding, the news on CS was welcomed by a few participants because they felt they stood to gain should they agree to go through the procedure. This attitude of a few of the participants was grounded on their earlier refusal to undergo the procedure which resulted in a negative outcome to them. The literature reports similar positive feelings given by women who have undergone CS [2,13]. These positive feelings suggest significantly to the fact that medical indications for CS is easily accommodated by some women.

4.2 Post CS Consequences

Most participating women appeared uncomfortable with their CS experience, because of the social abuse they received in their respective communities after the CS. Thus, for most of these women, giving birth spontaneously is a more empowering experience than giving birth by caesarean section. The results revealed a high level of ignorance about CS in the participants' communities. This issue was similarly reported by women in a previous study [12]. It is a belief that with CS one cannot attain the ideal family size in most African settings necessitates the need for a rival to prove her worth to the husband as custom demands was met by most of the study participants. Some were also being threatened by their husbands to marry a second wife because of their inability to deliver per vagina. The work of [25] have also provided some clue to the effect that when women undergo CS, it may negatively affect their health. This may serve as a basis to the rejection of Caesarian Section as a mode of delivery in the future should there be the need. This revelation is consistent with other studies [12]. Some other evidence provides proof that a woman whose prior pregnancy ended in a caesarean section is likely to have repeated caesarean sections with consequences like limited number of future childbirth [26]. In the contrary, other studies revealed that women will prefer small number of

children resulting from CS in order to give them better care [1]. This finding compare favourably with that of [23] which proves that feelings of women who give birth via caesarean section or vaginal delivery are less likely to be affected. This is because caesareans have gotten safer recently as a result of enhanced anaesthesia. Further and in part agreement with this current study, it is indicated that there is proof that both women and their unborn children are more likely to experience issues in later pregnancies [27]. Generally, the results of this bring to fore the urgent need for intensive education not only among women but the community as a whole on the right indications for CS as a birth strategy medically [28].

5. CONCLUSION

The findings indicate that women had varied beliefs about CS that tend to influence their reactions and acceptability of the procedure as a birth strategy. Women's reactions towards CS had cultural and social dimensions, hence they reacted differently towards the procedure. Women exhibited different emotive reactions towards CS such as depression, anxiety and positive emotions. Following CS, women suffered within the social context in which they found themselves, which had marital and social consequences. Public health units should intensify education of the public through the mass media on indications for CS to enrich their knowledge and to solicit the needed support from families and community members for women undergoing CS. Health care providers should organize tailor-made programmes on psychosocial counselling for women before and after CS.

6. LIMITATIONS

The study was limited in the sense that some of the potential participants were not included in the study due to health reasons or the conditions of their babies. This group of women could have provided very useful data for this study.

The study was confined to the Tamale metropolis which is just one part of the northern part of Ghana. This study cannot, therefore, be generalized to the whole of Ghana or the northern part of Ghana. Inspite of these limitations, the study provides insightful findings that will support health service delivery for positive outcomes.

CONSENT

The participants were informed their participation in the study was voluntary, and each participant was made sign a consent form to indicate her willingness to take part in the study. Data for this study was collected from women who experienced CS and were 18 years and above. Privacy was ensured during the interview session by avoiding a crowded environment.

ETHICAL APPROVAL

Ethical approval to conduct the study was obtained from the Institutional Review Board of Noguchi Memorial Institute for Medical Research University of Ghana, Legon (NMIMR-IRB CPN 033/17-18). Permission was obtained through formal writing from the chief executive of the Tamale Teaching Hospital through the research and monitoring unit of the hospital.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Boz İ, Teskereci G, Akman G. How did you choose a mode of birth? Experiences of nulliparous women from Turkey. Women and Birth. 2015;29(4):359–367. Available:https://doi.org/10.1016/j.wombi.2016.01.005
2. Tadevosyan M, Ghazaryan A, Harutyunyan A, Petrosyan V, Atherly A, Hekimian, K. Factors contributing to rapidly increasing rates of cesarean section in Armenia: A partially mixed concurrent quantitative-qualitative equal status study. BMC Pregnancy and Childbirth. 2019;19(1):1–10. Available: https://doi.org/10.1186/s12884-018-2158-6
3. Afaya RA, Bam V, Apiribu F, Agana VA, Afaya A. Knowledge of pregnant women on cesarean section and the preferred mode of delivery in Northern Ghana. International Journal of Nursing and Midwifery. 2018;1(1):1–12.
4. Naa Gandau BB, Nuertey BD, Seneadza NAH, Akaateba D, Azusong E, Yirifere JY, Kankpeyeng HB, & Tette EMA. Maternal perceptions about caesarean section deliveries and their role in reducing

perinatal and neonatal mortality in the Upper West Region of Ghana; A cross-sectional study. BMC Pregnancy and Childbirth. 2019;19(1):1–14.
Available:https://doi.org/10.1186/s12884-019-2536-8

5. Phuong LTN. Factors Influencing Intention of caeasarian section among pregnant women in Quang Ngai Province, Vietnam
6. Panda S, Begley C, DalyD. Influence of women's request and preference on the rising rate of caesarean section – a comparison of reviews. Midwifery. 88: 102765.
Available:https://doi.org/10.1016/j.midw.2020.102765
7. Betrán AP, Ye J, Moller AB, Zhang J, Gülmezoglu AM, Torloni MR. The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimate. 2016;1990-2014.
8. Panda S, Daly D, Begley C, Karlström A, Larsson B, Bäck L, & Hildingsson I. Factors influencing decision-making for caesarean section in Sweden - A qualitative study. BMC Pregnancy and Childbirth. 2018;18(1):1–8.
Available: https://doi.org/10.1186/s12884-018-2007-7
9. World Health Organization (WHO), Managing Complications in Pregnancy and Childbirth: a Guide for Midwives and Doctors, second ed., WHO, Geneva; 2017.
10. Sandall J, Tribe RM, Avery L, Mola G, Visser, GH, Homer CS, Gibbons D, Kelly NM, Kennedy HP, Kidanto H, Taylor P, Temmerman M. Short-term and long-term effects of caesarean section on the health of women and children. The Lancet. 2018;392(10155):1349–1357.
Available: https://doi.org/10.1016/S0140-6736(18)31930-5
11. Abdullahi YY, Assefa N, & Roba HS. Magnitude and Determinants of Immediate Adverse Neonatal Outcomes Among Babies Born by Cesarean Section in Public Hospitals in Harari Region, Eastern Ethiopia. Research and Reports in Neonatology. 2021;11:1–12.
Available:https://doi.org/10.2147/rrn.s296534
12. Ugwu NU, & De Kok B. Socio-cultural factors, gender roles and religious ideologies contributing to Caesarian-section refusal in Nigeria. Reproductive Health. 2015;12(1):1–13.
Available: https://doi.org/10.1186/s12978-015-0050-7
13. Takegata M, Smith C, Nguyen HAT, Thi HH, Minh TNT, Day LT, Kitamura T, Toizumi M, Dang DA, Yoshida, LM. Reasons for increased caesarean section rate in vietnam: A qualitative study among vietnamese mothers and health care professionals. Healthcare (Switzerland). 2020;8(1):1–15.
Available:https://doi.org/10.3390/healthcare8010041
14. Schantz C, de Loenzien M, Goyet S, Ravit M, Dancoisne A, Dumont A. How is women's demand for caesarean section measured? A systematic literature reviews. PLoS ONE. 2019;14(3): 1–14.
Available:https://doi.org/10.1371/journal.pone.0213352
15. Karlström A. Women's self-reported experience of unplanned caesarean section: Results of a Swedish study. Midwifery. 2017;50:253–258.
Available: https://doi.org/10.1016/j.midw.2017.04.016
16. Deninotti J, Denis A, Berdoulat É. Emergency C-section, maternal satisfaction and emotion regulation strategies: effects on PTSD and postpartum depression symptoms. Journal of Reproductive and Infant Psychology. 2020;00(00):421–435.
Available:https://doi.org/10.1080/02646838.2020.1793308
17. Mboho M. Perception of Nigerian women towards caesarian section: A Case Study of Women of Reproductive Age in Akwa Lbom State, Nigeria. 2013;4(6).
18. Ghana Statistical Service. Population and Housing Census. District Analytical Report, Tamale Metropolis; 2014.
Available:http://www.statsghana.gov.gh/docfiles/2010_District_Report/Northern/Tamale Metropolitan.pdf
19. Creswell JW. Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage; 2007.
20. Patton MQ, Cochran M. A Guide to Using Qualitative Research Methodology; 2002.
21. Francis JJ, Johnston M, Robertson C, Glidewell L, Entwistle V, Eccles MP, Grimshaw JM. What is an adequate sample size? Operationalizing data saturation for theory-based interview

studies. Psychology and Health. 2010; 25(10):1229–1245.
Available:https://doi.org/10.1080/08870440903194015

22. Fusch PI, Ness LR. Are We There Yet? Data Saturation in Qualitative Research. 2015; 20.
23. Lavender T, Hofmeyr GJ, Neilson JP, Kingdon C, Gyte GM. Caesarean section for non-medical reasons at term. Cochrane Database of Systematic Reviews. 2012; (3).
Available:https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004660.pub3/pdf/full
24. Størksen HT, Garthus-Niegel S, Adams SS, Vangen S, & Eberhard-Gran M. Fear of childbirth and elective caesarean section: a population-based study. BMC Pregnancy and Childbirth. 2015;15(1): 1-10.
Available:https://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/s12884-015-0655-4.pdf
25. Chen H, Tan D. Cesarean section or natural childbirth? cesarean birth may damage your health. Frontiers in Psychology. 2019;10:351.
Available:https://www.frontiersin.org/articles/10.3389/fpsyg.2019.00351/full
26. Dodd JM, Crowther CA, Huertas E, Guise JM, Horey D. Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth. Cochrane Database of Systematic Reviews. 2013;(12).
Available:https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004224.pub3/full
27. Rishworth A, Bisung E, & Luginaah I. "It's Like a Disease": Women's perceptions of caesarean sections in Ghana's Upper West Region. Women and Birth; 2016
Available:https://doi.org/10.1016/j.wombi.2016.05.004
28. Cavallaro FL, Cresswell JA, França VA, Victora CG, & Barros, J. D. Trends in caesarean delivery by country and wealth quintile: cross-sectional surveys in southern Asia and sub-Saharan Africa. 2015:914–922.

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